York Family Chiropractic - Dr. Ipchilar & Associates - 2991 Bathrust St, Toronto, ON M6B 3B3 - (416) 878-6789

HEALTH HISTORY FORM

Today's Date: _____

How did you hear about the clinic? Referred by : _____ ☐ Internet ☐ Social Media

☐ Get Healthy at Work Other_____

PATIENT DEMOGRAPHIC

Name: _____

Address: _____

Cell/ Home Phone#: _____

Email: _____

Employer: _____

Occupation: _____

Birth Date: Day _____ Month _____ Year_____

Age: _____ Male ____ Female ____

City _____ Province: _____

Postal code: _____

Name of Spouse: _____

Name & Ages of kids: _____

HEALTH GOALS

Please check all that apply:

☐ Be pain free ☐ Not have to take medication ☐ Lose weight ☐ Live a long, healthy life

If 100% healthy is feeling good everyday, where are you at today? _____%/ 100%

When was the last time you were pain free for a whole month? _____

DID YOU HURT YOURSELF AT WORK OR IN A CAR ACCIDENT?

Will you be claiming: Autopac/MVA : Y / N Workers Compensation: Y / N

If yes: Injury/Accident Date: _____ Personal Injury Claim #: _____

How many people were in the vehicle? _____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? Y / N Name of previous chiro: _____

Did you have x-rays taken? Y / N When was your last visit: _____

PROBLEM #1

What brought you into the office today? (Eg. Back pain, neck pain, headaches, etc.)

_____

On a scale of 1 to 10 with 10 being the worst pain, 8 being like giving birth to a child, and zero being no pain, rate how bad your pain feels by circling the number:

No Pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst Pain

When did the problem(s) begin?_____ How did the problem(s) begin? _____

Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same

How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly

How often do you feel the pain in a day?

☐ Constant 76-100% ☐ Frequent 51-75% ☐ Occasional 26-50% ☐ Intermittent 0-25%

Have you ever had the problem before? _____

What makes the pain better? _____

What makes the pain worse? _____

Describe the pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Shooting ☐ Numb Other:_____

PROBLEM #2

Is there anything else you want the doctor to look at?

_____

On a scale of 1 to 10 with 10 being the worst pain, 8 being like giving birth to a child, and zero being no pain, rate how bad your pain feels by circling the number:

No Pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst Pain

When did the problem(s) begin?_____ How did the problem(s) begin? _____

Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same

How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly

How often do you feel the pain in a day?

☐ Constant 76-100% ☐ Frequent 51-75% ☐ Occasional 26-50% ☐ Intermittent 0-25%

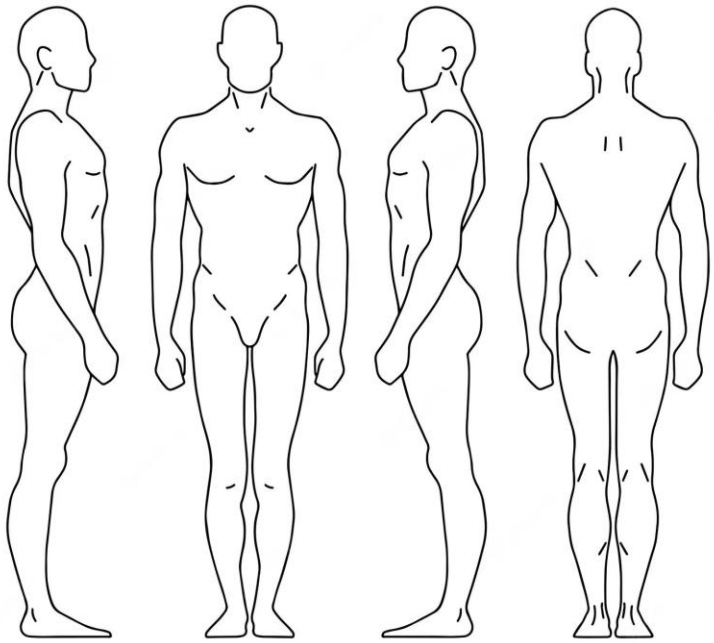
Have you ever had the problem before? _____

What makes the pain better? _____

What makes the pain worse? _____

Describe the pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Shooting ☐ Numb Other: _____

MARK "X" WHERE YOU FEEL PAIN:



LIFE AFFECT

How is the pain/health problem affecting your life? _____

_____

If you were pain free and healthy what would you be doing more of? _____

_____

PAINS AND HEALTH PROBLEMS

Have you experienced any of the following things in the last 6 months?

Headaches	☐	Leg Pain	☐	Digestive Issues	☐
Migraines	☐	Knee Pain	☐	Constipation	☐
Neck Pain	☐	Foot/ Ankle Pain	☐	Menstrual Cramps	☐
Shoulder Pain	☐	Chest Pain	☐	Difficulty Sleeping	☐
Upper Back Pain	☐	Ear Infections	☐	Asthma	☐
Mid Back Pain	☐	Diarrhea	☐	Dizziness	☐
Lower Back Pain	☐	Decreased Energy	☐	Numbness/ Tingling	☐

Other: _____

What medications are you taking?

High Blood Pressure	☐	_____
High Cholesterol	☐	_____
Heartburn	☐	_____
Gout	☐	_____
Anxiety	☐	_____
Depression	☐	_____
Diabetes	☐	_____

Other: _____

FAMILY HISTORY:

Do you have a family history of the following diseases?
If so please write down who and how old they are.

- ☐ Cancer: _____
- ☐ Heart Disease: _____
- ☐ Diabetes: _____
- ☐ Other: _____
- ☐ None

PAST SURGICAL HISTORY

Please list any prior surgeries you have had and dates : _____

_____

_____

LIFE IS BETTER WHEN EVERYBODY IS HEALTHY

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CONSENT TO CHIROPRACTIC

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

When a patient seeks chiropractic care in this office, it is essential for both the doctor and the patient to be working toward the same objective. Chiropractic science identifies the body as a self-healing and self-regulating being that is consistently adapting to its environment. This is achieved primarily through the central nervous system. Chiropractic has only one goal: to remove nervous system interference in the form of vertebral subluxation, thus restoring and maintaining the integrity of the spinal cord and its nerve roots.

There are vital communication pathways, essential for proper health, which travel to every organ, tissue and cell in the body, including the immune system. Chiropractors use specific chiropractic adjustments to reduce and remove nervous system interference, done either by hand or by instrument. This allows the proper flow of informational messages from the brain along these nerve pathways to every part of the body. This is critical for optimal health and well-being.

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, nor do we offer advice regarding treatments prescribed by others. However, if during the course of your chiropractic care we encounter non-chiropractic or unusual findings, we will advise you on a possible referral. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of someone who specializes in that area. Be advised this will not interfere with your current chiropractic care plan.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ _____ Date: _____20____
Signature of patient (or legal guardian) Signature of Chiropractor